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September 25, 2007

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PENDING CHANGES TO THE STARK LAW PHASE III

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On September 5, 2007, the Centers for Medicare & Medicaid Services (CMS) published its long-awaited Phase III regulations regarding the federal ban on physician self-referrals, more commonly known as "Stark." CMS claims that the Phase III Stark regulations, effective on December 4, 2007, will reduce the regulatory burden on the health care industry, "simplify" the rules and provide additional guidance to hospitals and physicians seeking to comply with the Stark law. While some of the changes do provide a certain amount of flexibility, it is doubtful whether anyone seeking to comply with the Stark law would find that these regulations do anything to simplify what is already an extraordinarily complex body of law. Moreover, the new "stand in the shoes" rule for indirect compensation arrangements belies the government's claim of reduced regulatory burden in that it likely will require many arrangements to be restructured.

In light of proposed changes to Stark contained in the Medicare Physician Fee Schedule and the upcoming Stark law compliance initiative targeting 500 hospitals regarding disclosures of hospital-physician relationships, Phase III is not the final word on Stark. Nevertheless, this E-lert highlights a few of the most notable changes to the Stark Law that are most likely to impact our clients. For additional guidance on a particular issue or a more complete analysis of this lengthy new regulatory guidance, please contact any member of our Health Law Group listed below.

PHYSICIAN RECRUITMENT EXCEPTION

The purpose of the physician recruitment exception is to allow hospitals, federally qualified health centers, and now rural health clinics (collectively referred to as "hospitals" in this exception) to provide remuneration to physicians to induce them to relocate their practices to the hospital's geographic service area. While there are numerous Phase III revisions to the physician recruitment and retention rules, only time will tell whether those revisions actually give hospitals greater flexibility in recruiting physicians. The key Phase III changes to the physician recruitment exception include, among others, the following:

Geographic Service Area. Phase III provides hospitals new flexibility for recruiting by loosening the definition of the "geographic area served by the hospital." It clarifies that, to qualify for the exception, a recruited physician must relocate his or her practice from outside the geographic service area to a location inside the service area and either: (1) move his or her medical practice at least 25 miles; or (2) open a new practice that derives at least 75% of its revenues from professional services to patients not seen at the physician's prior practice during the preceding 3 years.

Reasonable Practice Restrictions. Phase III provides added flexibility to group practices by permitting them to impose practice restrictions on the recruited physician that do not "unreasonably restrict" the recruited physician's ability to practice in the geographic service area. Such restrictions could include, for example, repayment of losses; a limited, reasonable non-compete clause; and a prohibition on moonlighting.

Incremental Costs and Replacing Physicians. Phase III modifies the recruitment exception to allow a hospital to provide more generous income guarantees to recruit a physician to join a physician practice located in a rural area or a health professional shortage area, if the physician is recruited to replace a deceased, retiring or relocating physician.

Group Reimbursement. Phase III describes types of expenses for which a hospital can reimburse a group practice as part of "actual costs incurred" when recruiting a physician into the practice and community. Such expenses include headhunter fees, tail malpractice insurance from the recruited physician's previous practice, moving expenses, airfare, hotels and other costs incurred for visits to the new practice group area by the physician and his/her family.

Relocation. Another Phase III change exempts from the relocation requirement physicians who were, for the 2 years prior to the recruitment arrangement, employed full-time by a federal or state bureau of prisons (or similar entity), the Department of Defense, the Department of Veterans Affairs or facilities of the Indian Health Services. This change will likely help in recruiting physicians who have worked off student loans through public service activities.

Space Sharing. The recruitment exception does not apply to recruitment of physicians who join an existing practice when the recruited physician is merely co-locating or sharing space with an existing practice.

COMPENSATION ARRANGEMENTS

Physician Organization. The Phase III regulations make important changes to the provisions addressing compensation arrangements between physicians, their group practices, and DHS entities. A new definition, "physician organization," is added to broadly include a referring physician's professional corporation, physician practice, or group practice.

"Stand in the Shoes." Phase III introduces a broader "stand in the shoes" rule for purposes of determining whether a physician has a direct or indirect financial relationship with a DHS entity. Under the new regulations, a physician is deemed for these purposes to "stand in the shoes" of his or her physician organization, and thus to have the same financial relationship with the entity as does the physician organization. As a result, for example, a compensation arrangement between a hospital and a physician group that previously constituted only an indirect compensation arrangement between the hospital and the group's individual physicians is now treated as a direct compensation arrangement between the hospital and each of the individual physicians. Notably, CMS has exempted from this new rule existing arrangements, entered into prior to the publication date of the Phase III regulations, that were properly structured to comply with the indirect compensation arrangement exception. This new rule will require many physicians to reexamine existing arrangements to determine if they are affected by the broader definition, particularly if they had determined that they either did not meet the former definition of indirect compensation interest, thereby falling outside the ambit of the law, or they had previously concluded they met the indirect compensation exception. Going forward, affected transactions will ONLY be exempt from Stark if the physician organization has an arrangement with the DHS entity that meets one of the direct compensation exceptions.

CMS raised concerns of potential abuse with arrangements involving an intervening entity between the referring physician and the DHS entity other than a physician organization (for example, a management company or leasing company) and indicated that CMS would solicit additional public input on the best way to apply a "stand in the shoes" rule to these indirect relationships.

MEMBERSHIP AND COMPENSATION WITHIN A GROUP PRACTICE

Physician in the Group Practice. The Phase III regulations also modify the rules applicable to physician membership and compensation within a group practice. The definition of "physician in the group practice" now requires a direct contractual relationship between each such physician and the group practice. Consistent with that approach, the regulations provide that an independent contractor constitutes a "physician in the group practice" only to the extent that "he or she is performing services in the group practice's facilities and, thus, has a clear and meaningful nexus with the group's medical practice."

Profit Sharing and Productivity Bonuses. Phase III also addresses prior confusion over permissible profit sharing and productivity bonuses. Under the pre-Phase III regulations, profit shares and productivity bonuses a group practice awarded to its physicians could both be based on personally performed services, including services provided "incident to" those personally performed services, provided the shares and bonuses were not determined in any manner that was "directly related" to the referring physician's volume or value of DHS referrals. The Phase III regulations, however, make clear that a practice may no longer base profit sharing on the volume or value of any DHS billed as an "incident to" service.

Productivity bonuses, by contrast, may continue to be based directly on "incident to" services that are incidental to the physician's personally performed services, even if those "incident to" services are otherwise DHS referrals. In determining such bonuses, any "incident to" services must be attributed to the ordering physician and, significantly, "diagnostic tests" are not to be considered "incident to" services.

NONMONETARY COMPENSATION EXCEPTION

In Phase III, CMS created a mechanism for an entity to cure excess inadvertent nonmonetary compensation. Nonmonetary compensation will be deemed to be within the limit set by CMS if the amount in excess does not exceed 50% of the amount allowed ($329 in 2007) and the physician repays or returns the excess nonmonetary compensation within the earlier of: (1) the end of the calendar year in which the excess compensation was received; or (2) 180 days from the date the excess compensation was received. This repayment provision can only be used once every three years with respect to the same physician. Phase III also adds an exception to allow an entity that has a formal medical staff to provide one medical staff appreciation event per year for the entire medical staff. The cost of the event would not count toward the dollar limit for the nonmonetary compensation exception; however, any gifts or gratuities provided in connection with the event would be subject to that limit.

PROFESSIONAL COURTESY EXCEPTION

Phase III relaxed the professional courtesy exception by deleting the requirement that an entity notify an insurer when the professional courtesy involves the whole or partial reduction of any coinsurance obligation. CMS did, however, state that it believes that it would be a "prudent practice" for entities to provide such notification.

PROPOSED CHANGES FROM PHYSICIAN FEE SCHEDULE RULE

In contrast to Phase III, which CMS claims will give hospitals added flexibility, there seems to be little doubt that the proposed changes in the July 2, 2007 Proposed Medicare Physician Fee Schedule ("MPFS Proposed Rule") would likely curtail use of several common practices. While this is only a proposed rule, the following changes would suggest that CMS is trying to close what it perceives as loopholes in hospital-physician relationships. The following five areas are of particular concern:

Under Arrangement Services. When referring physicians own an interest in the DHS entity, under arrangement services between hospitals and referring physicians will not be permitted.

Per Click Arrangements. Arrangements in which referring physicians lease equipment or space to hospitals, which pay per use, must be restructured so that they are based on hourly or daily fair market values.

Percentage-based Compensation. Percentage-based compensation arrangements may include only revenue generated from services personally performed by a physician.

Technical Violations. When a provider becomes aware of even "technical" Stark violations, it would be expected to self-report.

Purchased Professional Services. Marking up of purchased professional services will be limited to the lesser of the net charge, actual charge, or fee schedule.

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